AGREEMENT
BETWEEN
_____(Area Authority/County Program)
AND
(PROVIDER Corporate Name)
A DIRECT ENROLLED PROVIDER OF ENHANCED MH/DD/SA SERVICES FUNDED BY MEDICAID

THIS AGREEMENT is made between _____ (herein known as the 'Area Authority/County Program"), and _____, (herein known as the "Provider"), operating under the laws of North Carolina. By means of this Agreement, the Area Authority/County Program is establishing a relationship with Providers of Medicaid covered services.

RECITALS

The Area Authority/County Program and the Provider enter into this Agreement to govern Provider's provision of mental health, developmental disabilities and substance abuse services to individuals referred to it by the Area Authority/County Program.

Area Authority/County Program initially screens individuals seeking or needing mental health developmental disabilities and substance abuse services, and coordinates treatment by provider participants.

Individuals covered by Medicaid who are in need of mental health, developmental disability and substance abuse services, consistent with their right of choice, choose providers for their services from list of provider participants endorsed by the Area Authority/County Program.

Provider represents that it is a qualified provider of one or more mental health, developmental disabilities and substance abuse services funded by Medicaid who has been so endorsed by an Area Authority/County Program through the North Carolina Department of Health and Human Services ("DHHS").

This Agreement sets forth provisions pursuant to which Provider will provide mental health, developmental disabilities and substance abuse services to individuals who have chosen Provider for such services.

NOW, THEREFORE, the Parties agree as follows:

Provider will provide mental health, developmental disabilities and substance abuse services to individuals who have chosen Provider for such services pursuant to and in compliance with the provisions of this Agreement.

Area Authority/County Program will provide access to such services to individuals, as well as quality assurance and monitoring relating to such services pursuant to and in compliance with this Agreement.

ARTICLE I
RIGHTS AND OBLIGATIONS OF THE AREA AUTHORITY/COUNTY PROGRAM

1.1 Operations Manual. The Area Authority/County Program shall provide to the Provider a copy of the "Operations Manual". The Provider acknowledges receipt of the Operations Manual by signing this Agreement. If the terms of this Agreement conflict with information contained in the Operations Manual, the terms of the Agreement shall control.

1.2 Notification of Applicable Regulations. The Area Authority/County Program shall make available to Provider copies of or access to all pertinent rules, regulations, standards, and other information distributed by DHHS that are necessary for Provider's performance under the terms of this Agreement. It is Provider's responsibility to access that information. The Area Authority/County Program shall notify Provider of any substantive change in rule or regulation as soon as possible after receipt of the information from DHHS. A list of rules and regulations is part of the Operations Manual.

1.3 Monitoring Under Standards. The Area Authority/County Program shall be given full opportunity by Provider to review performance indicators on-site to evaluate compliance with the rules of the North Carolina Commission for Mental Health, Developmental Disability, and Substance Abuse Services (the "Commission"), the Secretary of the Department of Health and Human Services, and applicable law. The Area Authority/County Program has the authority to conduct local monitoring to evaluate compliance with Federal, DHHS, Medicaid, and other applicable rules and statutes (see Operations Manual) and Provider shall cooperate with Area Authority/County Program in such monitoring. The frequency and the intensity of the local monitoring will be in the discretion of the Area Authority/County Program.

1.4 Informed Choice of Provider. The Area Authority/County Program provides information to individuals covered by Medicaid regarding their rights to choice of Provider as governed by State and Federal law. The information includes names, contact information and locations of all Providers who have been endorsed by Area Authority/County Program. The Parties agree to rely upon DHHS to maintain a website listing all Providers endorsed to provide MH/DD/SA services within North Carolina.

1.5 Endorsement of Providers of Medicaid Funded Services. All Medicaid Providers enrolled and in good standing with Division of Medical Assistance and endorsed by the local Area Authority/County Program shall be deemed part of local Provider community. Endorsement (the verification and quality assurance process) of a Provider of Medicaid covered services is a DHHS statewide procedure followed by all Area Authorities and County Programs. The endorsement of a Provider will follow the signing of this Agreement and prior to the enrollment with DMA.

1.6 Training and Technical Assistance. The Provider must attend all relevant Orientation Sessions as determined by the Area Authority/County Program at no cost to the Provider. The Provider shall attend all mandatory trainings as related to business practices at no charge to the Provider as space permits. The Area Authority/County Program reserves the right to charge the usual and customary fee for additional staff attendance or scheduling additional trainings to meet Provider demand. The Area Authority/County Program shall also mandate Provider attendance at selected Clinical Sessions of which the Provider bears the cost, whether Area Authority/County Program sponsored or offered by outside Parties. The Provider shall also bear the cost of all trainings related to licensure or accreditation activities. The Provider must be able to demonstrate to Area Authority/County Program its application of training information received in the delivery of services and in compliance with the provisions of this Agreement.

1.7 Screening, Triage and Referral. The Area Authority/County Program will work with community agencies to ensure that individuals can enter the system through many avenues in order to receive timely and effective service. An individual may seek access to the service system by contacting the Area Authority/County Program, Providers or other community agencies. Individuals seeking access to services shall have an initial screening and triage by the Area Authority/County Program (or its contract agent) in order to determine if an MH/DD/SA need exists and ensure appropriate disposition. The Screening, Triage & Referral (STR) staff will complete an initial screening and the STR staff will then contact the provider of choice (or in the absence of consumer preference) an appropriate provider who represents an appropriate consumer-provider match to complete a comprehensive diagnostic assessment. TTY capability for persons, who have a hearing impairment, and foreign language interpretation, will be provided to the person making the referral or to the individual seeking service for the purposes of receipt of appropriate information for referral of services at no cost where necessary.

ARTICLE II
RIGHTS AND OBLIGATIONS OF DIRECT ENROLLED PROVIDERS OF MEDICAID COVERED SERVICES

2.0 Covered Services. Provider agrees to provide to individuals eligible for such services the Covered Services identified in Attachment A and all addenda in accordance with all requirements set forth or referenced in the Operations Manual and all subsequent revisions.

2.1 Maintenance of Facility Licensure, Accreditation and Credentialing. Provider and its agents providing services on its behalf under this Agreement shall obtain and maintain in good standing all applicable accreditation(s), licenses and certificates required by DHHS policy or law, including but not limited to licensure required by all appropriate agencies and/or Boards. The Provider and its agents providing services on the Provider's behalf under this Agreement shall continuously during the term of this Agreement meet all credentialing and privileging/competency standards as described in this Agreement, the Operations Manual or as required by law, policy or regulation.

2.2 Service Record Compliance for Enhanced Benefit Providers. Provider shall maintain a Service Record for each Individual served in accordance with the Service Records standards set forth by the state or federal law, Division's regulation or DHHS policy. The original Service Record related to services provided in accordance with this Agreement shall be accessible for review for the purpose of monitoring services rendered, financial audits by Medicaid or by third Party payers and research and evaluation. Service records shall be retained for the duration and the format prescribed by Area Authority/County Program and by State and Federal law, regulation and policy. If for any reason Provider can no longer maintain the Service Record, Provider will contact the Area Authority/County Program staff member responsible for Service Records to facilitate resolution. Upon request, Provider shall provide data about individuals for research and study to the Area Authority/County Program as permitted or required by DHHS and applicable Federal law. Upon request, Provider shall provide Service Records information about consumers referred by the Area Authority/County Program for Quality Assurance and Utilization Management purposes of the Area Authority/County Program.

2.3 Rights of Individuals. Provider shall conduct activities in a manner that shall deter, prevent, and avoid abuse, neglect, and/or exploitation of individuals in its care and to ensure compliance with all DHHS and Federal requirements and in accordance with the policies of Area Authority/County Program. The Enhanced benefit Provider agrees to maintain policies, procedures and monitoring as required in the DHHS Client Right's policy, the Operations Manual and the policies of Area Authority/County Program.

2.4 Adverse Selection. Provider shall be prohibited from arbitrarily declining, refusing to serve or ejecting consumers for the covered services under this Agreement. In the event that Provider declines a referral, refuses to serve or ejects a specific consumer, Provider shall give Area Authority/County Program specific reason for the decline, refusal or denial. In all cases of adverse selection, Provider must provide timely reasons and where applicable, notice to ensure that continuity of care can be optimized. Area Authority/County Program may consider information regarding adverse selection in its evaluation of Provider.

2.5 Service Coordination. For purposes of this Agreement, "provider participant" shall refer to all service providers to whom the Area Authority/County Program refers consumers. Continuity of care is expected for all individuals served under this Agreement. In an effort to improve the coordination of supports and services within the Area Authority/County Program's community of providers, Provider agrees to use good faith efforts to coordinate supports and services with other

provider participants, Carolina Access and other primary care providers for all individuals served under this Agreement. The Provider shall obtain appropriate client authorizations and consents to release or exchange information. The Provider shall endeavor to participate in team meetings and/or community collaborations and communicate regularly with other providers regarding mutual cases. The primary service provider who engages an Independent Practitioner (a directly enrolled clinician providing outpatient therapy) to serve consumers receiving enhanced benefits will maintain a MOA/or a contract with the Independent Practitioner to ensure care coordination. Providers who act as the clinical home such as those delivering Community Support, Community Support Team or Targeted Case Management Services must either provide or arrange and coordinate appropriate psychiatric services when consumers need them.

2.6 Quality Management. Provider of enhanced benefits shall conduct a quality management program in accordance with the DHHS policies and agrees to provide evidence of assessment of quality of care and best practices, effectiveness and satisfaction with services to the Area Authority/County Program upon request. Provider shall abide by the treatment protocols, requirements for person-centered planning and implement evidence-based practices as defined and adopted by the Division of MHDDSA and any subsequent revisions. Provider shall ensure that corrective action is taken on a timely basis to address problems found through the quality management process.

2.7 Clinical Outcome Measures: At a minimum, the enhanced benefit Provider shall complete the NC-TOPPS for the designated populations as well as all other DMHDDSA required outcomes assessments on clients admitted during each calendar quarter in accordance with Department guidelines and any subsequent changes thereto. (See attached Operations Manual). The Area Authority/County Program shall define the guidelines for obtaining and submitting the outcomes data and convey this information to Provider. The appropriate outcome instrument to be used for a specific client will be dependent upon the age and primary disability category of the client and any changes made to these requirements by the Department of Health and Human Services through any outcome transition plan with the Area Authority/County Program.

2.8 Incident Reporting. Provider shall report and respond to all client incidents as required under State and Federal law, rules and regulations. Incidents shall be reported in the manner prescribed and on a form provided by the Secretary of DHHS. (See Operations Manual)

2.9 Reports of Regulatory Authorities. Copies of surveys, reviews and/or audits performed by primary accrediting or regulatory authorities of Provider and utilized to confirm operational compliance of Provider and require corrective action on the part of Provider shall be provided to the Area Authority/County Program upon receipt by Provider.

2.10 Suspension or Debarment. Provider certifies by signing this Agreement that neither it nor its agents have been suspended or debarred by any applicable governmental authority from conducting any business or activities contemplated by this Agreement whether under current corporate name or any additional name or former name, including the current or former name of a division department, program or subsidiary.

2.11 Liability Insurance. Provider, prior to service delivery, shall provide proof of and continuously maintain insurance coverage with a carrier authorized to do business in North Carolina, or maintain equivalent coverage under a self-insurance program that is approved by the North Carolina Department of Insurance. Liability coverage may be on an occurrence basis or claims-made basis. If the policy is on a claims-made basis, an extended reporting endorsement (tail coverage) shall also be provided for a period of not less than three (3) years after the end of the term of this Agreement, or an endorsement shall be provided for continued liability coverage with

a retroactive date on or before the beginning of the term of this Agreement or any prior agreement between Provider and Area Authority/County Program.

Provider shall acquire and maintain:

a) Commercial General Liability:

Provider shall maintain bodily injury and property damage liability coverage as shall protect Provider and any approved subcontractor performing work under this Agreement from claims of bodily injury or property damage which arise from operations of this Agreement whether such operations are performed by Provider, any subcontractor or anyone directly or indirectly employed by either. The amounts of such insurance shall not be less than $1,000,000.00 each occurrence and $3,000,000.00 in the annual aggregate unless Provider, with prior written approval of Area Authority/County Program, names the Area Authority/County Program as an additional insured, in which case limits of no less than $1,000,000.00 each occurrence and $1,000,000.00 in the annual aggregate would be acceptable.

b) Professional Liability (where applicable):

Provider shall maintain such professional liability insurance coverage as shall protect the Provider's from its failure to conform to the professional standard of care required under applicable law and under this Agreement. The limits of liability shall be not less than $1,000,000.00 per occurrence and $3,000,000.00 in the annual aggregate. The Organization's professional liability insurance policy shall name the Area Authority/County Program as additional insured. An original, signed, in force Certificate of Insurance for such coverage shall be provided to the Area Authority/County Program upon execution of this Agreement and throughout the duration of this Agreement as insurance expires.

c) Automobile Liability:

Fleet vehicles, privately owned cars or hired cars utilized in the transport of consumers shall be insured against loss in an amount not less than $500,000.00 bodily injury each person, each accident, and $500,000.00 for property damage and $500,000.00 uninsured /under insured motorist; and $5,000.00 medical payment.

d) Worker's Compensation and Occupational Disease Insurance:

Provider shall meet the statutory requirements of the State of North Carolina for Worker Compensation and Occupational Disease Insurance, currently $100,000.00 per accident limit, $500,000.00 disease per policy limit, $100,000.00 disease each employee limit, providing coverage for employees and owner.

e) Certificates of Insurance:

The Provider agrees to notify the Area Authority by telephone and by providing written notice within five (5) days after receipt of information that the insurance carrier either intends to amend or terminate a policy or has amended or terminated any insurance policy providing the coverage referred to above. If Provider changes insurance carriers during the performance period of this Agreement, Provider shall provide evidence to the Area Authority within five (5) days. Subcontractors, as part of the approval process by the Area Authority/County Program, must be required by Provider to meet all the insurance requirements of this Agreement, including

providing the Area Authority/County Program with certificates of such insurance. Nonetheless, this does not relieve Provider from maintaining full coverage as well.

2.12 Federal Requirements. Provider shall comply with all governmental requirements applicable to the services being provided and to its operations, including, but not limited to the Certification Regarding Environmental Tobacco Smoke: Certification Regarding Lobbying: Certification Regarding Drug-Free Workplace Requirements: and Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion-Lower Tier Covered Transactions.

2.13 Clinical Information Data Submission. Providers that are authorized to conduct an assessment of a referred individual will submit all required data elements electronically within 5 calendar days of the last assessment session to the Area Authority/County Program, using the protocol(s) and formats described in the Operations Manual. Provider shall establish review procedures to ensure that a minimum of 90 percent of all elements for each record are complete and accurate and a minimum of 85 percent of all elements for each record are coded as something other than "Other" or "Unknown" within 30 days of first submission. Providers shall submit outcome instruments required by the Division of MH/DD/SAS in an amount, manner and schedule as described in the Operations Manual and as referenced in the most recent version of the Client Data Warehouse (CDW).

2.14 First Responder for Crisis/Emergency. If Provider is delivering a service with defined first responder responsibilities or who are designated in the Person Centered Plan (PCP) (which will include a comprehensive crisis plan) shall act as first responder to individuals referred by Area Authority/County Program if and when the individual and/or a member of their support system initiates contact for assistance involving a psychiatric crisis or emergency. Only those individuals whose distress represents a clear and present danger to self or others, and/or those individuals whose level of distress is not alleviated following reasonable efforts, shall be referred to Area Authority/County Program's crisis service. Provider shall notify the individual and his/her support system of the process for accessing crisis/emergency services 24 hours a day, 7 days a week, 365 days a year, both orally and in writing at initial contact. The notification shall include contact information for an alternate source of assistance in the eventuality that Provider is not available. Crisis services do not require prior authorization from Area Authority/County Program.

2.15 Utilization Management Requirements. Provider shall abide by Medicaid medical necessity criteria. Provider shall make every reasonable effort to see individuals within immediacy of need time frames (emergency, urgent, routine). Provider shall seek authorization prior to service delivery and provide accurate and thorough information requested so that service provision is not unduly delayed or disrupted.

2.16 Preservation of DHHS Public Funds. Provider shall demonstrate good faith efforts to seek alternative and/or supplemental sources of financing so as to reduce dependency on government monies. Providers offering mental health and/or substance abuse services on an outpatient basis shall demonstrate good faith efforts to seek and/or maintain membership on major commercial insurance panels, including but not limited to Blue Cross/Blue Shield.

2.17 Response to Survivors of Disasters and other Hazards, If designated by Area Authority/County Program, Provider, under the direction of the Area Authority/County Program and in coordination with the local Emergency Management agency(ies) shall deploy behavioral health disaster responders to deliver behavioral health disaster services to survivors and other

responders within the counties served by Area Authority/County Program. Behavioral health disaster services may be required at the site of a disaster, in emergency shelters, on the telephone/TTY machine, and other sites in which other disaster response agencies provide information or services to survivors and responders (e.g., FEMA Disaster Application Centers, emergency medical intervention, decontamination or quarantine sites). When it is determined that survivors or other disaster responders are in need of longer term mental health, developmental disabilities, and/or substance abuse services, Provider's behavioral health disaster responders shall refer such persons in need to the Area Authority/County Program or its designee for further assistance.

ARTICLE III
ADDITIONAL PROVISIONS

3.1 Health Insurance Portability and Accountability Act (HIPAA). The Provider and the Area Authority/County Program shall comply with current HIPAA privacy and security rules and regulations as in effect from time to time and each Party shall provide evidence to the Area Authority/County Program of this compliance upon request as embodied in Attachment B titled Qualified Service Organization and 42 CFR, Part 2. This includes, but is not limited to, the responsibility of each Party to determine when it is exchanging non-treatment-related information with the other Party or with other entities, in order to obtain or perform a business service related to the performance of this Agreement, and to implement a specific business agreement with the other Party or other entity if so. The Parties hereto specifically agree to amend this Agreement on a timely basis as necessary to comply with any and all laws relating to privacy and/or security of healthcare information, including the Health Insurance Portability and Accountability Act of 1996 (45 CFR Parts 160, 162 & 164 and 42 CFR, part 2 and any subsequent modifications thereof.

3.2 Confidentiality. Provider and Area Authority/County Program shall protect the confidentiality of any and all individuals and will not discuss, transmit, or narrate in any form other information, medical or otherwise, received in the course of providing services hereunder, except as authorized by the individual, his legally responsible person, or as otherwise permitted or required by law. The Provider and Area Authority/County Program shall, in addition, meet all confidentiality requirements promulgated by any applicable governmental authority.

3.3 Governing Laws. The laws of the State of North Carolina shall govern the validity and interpretation of the provisions, terms, and conditions of this Agreement. Venue over any action arising out of this Agreement shall lie only in the county(s) in Area Authority/County Program's catchment area.

3.4 Entire Agreement; Modification. This Agreement, along with the Operations Manual and other standards or documents specifically incorporated herein, constitutes the entire understanding of the Parties and this Agreement shall not be altered, amended, or modified except by an agreement in writing, properly executed by the duly authorized officials of both Parties.

3.5 Dispute Resolution. The Parties shall first attempt to resolve any disagreement between them through the DHHS Appeals Process. However, a failure to do so shall not operate as a failure to exhaust administrative remedies.

3.6 Invalid Provisions. If any term, provision, or condition of this Agreement is found to be illegal, void, or unenforceable by a court of competent jurisdiction, the rest of this Agreement shall remain in full force and effect. The invalidity or unenforceability of any term or provision of this Agreement shall in no way affect the validity or enforceability of any other term or provision.

3.7 Hold Harmless. The Area Authority/County Program and Provider agree to each be solely responsible for their own acts or omissions in the performance of each of their individual duties hereunder, and shall be financially and legally responsible for all liabilities, costs, damages, expenses and attorney fees resulting from, or attributable to any and all of their individual acts or omissions. No Party shall have any obligation to indemnify the other, and/or its agents, employees and representatives.

3.8 Compliance with Title VI and VII. Provider shall comply with Title VI and VII of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act of 1990 (ADA), and all requirements imposed by Federal regulations, rules, and guidelines issued pursuant to these Titles for both personnel employed and individuals served.

3.9 Independent Contractor. This Agreement is not intended and shall not be construed to create the relationship of agent, servant, employee, partnership, joint venture, or association between Provider and Area Authority/County Program, their employees, partners, or agents, but rather is an agreement by and among independent contractors; provided this shall not be construed to preclude Provider from utilizing service agreements for provision of professional services in place of employment agreements.

3.10 Subcontracting. Provider shall not subcontract or assign any of the services contemplated under this Agreement without obtaining prior written approval from the Area Authority/County Program. Any approved subcontracts or assignments for program delivery shall be subject to all conditions of this Agreement. The Area Authority/County Program may assign its rights and obligations under this agreement without approval of providers.

3.11 Non-Exclusivity. This Agreement is not exclusive. Area Authority/County Program and Providers have the right to enter into a similar agreement with any other Area Authority/County Program and/or other providers at any time.

3.12 Mergers, Name Changes and Acquisitions and Changes in Ownership or Control. Provider shall be responsible for notification to the Division of Facility Services and to Area Authority/County Program of all such changes when required to do so. Each Party shall promptly notify the other in writing regarding any merger, name change, acquisition of another company, and change in ownership or control. The surviving entity shall be bound by all the terms and conditions of this Agreement. Area Authority/County Program may terminate this Agreement in its discretion if Provider is acquired, merged or experiences a change in ownership or control.

3.13 Conflict of Interest. Provider and Area Authority/County Program will comply with all applicable law regarding Conflict of Interest.

3.14 Coordination of Benefits. Provider agrees to assist in the coordination of each individual's health care benefits so as to avoid undue delay in the provision of service and to ensure that Federal, state and local funding shall be used only if and when other sources of first and third Party payment have been exhausted. Providers shall make every reasonable effort to verify all insurance and other third Party benefit plan details during first contact, so that persons are directed to appropriate Providers and to comply with North Carolina law. Where available Provider is required to bill a consumer's private insurance. During an emergency, Provider shall provide the necessary services and then assist to coordinate payment.

3.15 Response Time. Provider shall implement policies, procedures, performance standards and monitoring and shall consistently provide adequate staffing and scheduling to ensure compliance with the Division of MH/DD/SA Services' "immediacy of need protocol", such that: 1. Individuals in emergency status, meaning a situation which threatens the health, safety or welfare of the Individual and/or of others, shall result in a face-to-face assessment which shall commence no later than two hours from notification to either Party, 2. Individuals in urgent status, meaning their situation is likely to escalate into an emergency, must be seen face-to-face (assessment and/or services) within 48 hours of first notification, 3. Individuals with routine needs must be seen face-to-face (assessment and /or services) within seven (7) calendar days of first notification, and 4.

Individuals released/discharged from a state hospital or institution must be seen within 5 days of release.

ARTICLE IV
TERM AND TERMINATION

4.1 Term: The term of this Agreement shall be for a three-year period commencing.

4.2 Provider Termination. This Agreement may be terminated at any time by the provider after ninety (90) days upon written notice of termination.

4.3 Area Authority/County Program Termination. Area Authority/County Program may immediately terminate this Agreement for cause. The cause for termination shall be documented in writing presented to the other Party detailing the grounds for termination. The endorsing Area Authority/County Program has the exclusive right to terminate this agreement.

4.4 Notice: Either Party may at any time change its address for notification purposes by mailing a notice to the other Party at the address designated by that Party. The new address shall be effective on the date specified in such notice, or if no date is specified, on the tenth (10th) day following the date such notice is received.

4.5 Option for Limited Renewal: The Area Authority/County Program may, by written notice to the Provider executed by the Area or Program Director, extend the term of this Agreement.

Provider name/ address

Federal ID No. _____

By_____DATE_____

Title_____
_

Area Authority/County Program name/address

_____

DULY AUTHORIZED OFFICIAL **DATE**

ATTACHMENT A
(Each Area program designs**)**

LIST OF SERVICES

(Provider Name)

SERVICE	ENDORSED SERVICES	EFFECTIVE DATES
*Ambulatory Detoxification		
*Assertive Community Treatment Team – ACTT		
Child and Adolescent Day Treatment (MH/SA)		
*Community Support – Adults (MH/SA)		
*Community Support – Children/Adolescents (MH/SA)		
*Community Support Team – CST (MH/SA)		
*Developmental Therapy Services		
*Diagnostic Assessment (MH/DD/SA)		
*Inpatient Hospital Psychiatric Treatment (MH)		
*Inpatient Hospital Substance Abuse Treatment		
*Intensive In-Home Services		
*Medically Supervised or ADATC Detoxification/Crisis Stabilization		
*Mobile Crisis Management (MH/DD/SA)		
*Multisystemic Therapy – MST		
*Non-Hospital Medical Detoxification		
*Psychiatric Residential Treatment Facility – PRTF		
*Psychosocial Rehabilitation – PSR		
*Social Setting Detoxification		
*Substance Abuse Comprehensive Outpatient Treatment Program		
*Substance Abuse Halfway House		
*Substance Abuse Intensive Outpatient Program		
*Substance Abuse Medically Monitored Community Residential Treatment		
*Substance Abuse Non-Medical Community Residential Treatment		
*Targeted Case Management for Individuals with Developmental Disabilities		
Facility Based Crisis Program		
Opioid Treatment		
Day Treatment – Child		
Personal Care		
CAP Services		
Level II, III & IV Residential Services		

This document may be amended to encompass additional endorsement by attaching a letter of the Notification of Endorsement Action to the MOA for each new service endorsement.

ATTACHMENT B

BUSINESS ASSOCIATE OR QUALIFIED SERVICE ORGANIZATION AGREEMENT

This Agreement is made effective the **1st of July 200-**, by and between Provider, hereinafter referred to as "Covered Entity" and Area Authority/County Program hereinafter referred to as "Business Associate or Qualified Service Organization", (individually, a "Party" and collectively, the "Parties").

WITNESSETH*:*

WHEREAS, Sections 261 through 264 of the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, known as "the Administrative Simplification provisions," direct the Department of Health and Human Services to develop standards to protect the security, confidentiality and integrity of health information; and

WHEREAS, pursuant to the Administrative Simplification provisions, the Secretary of Health and Human Services has issued regulations modifying 45 CFR Parts 160 and 164 (the "HIPAA Security and Privacy Rule"); and

WHEREAS, the Parties wish to enter into or have entered into an arrangement whereby Business Associate or Qualified Service Organization will provide certain services to Covered Entity, and, pursuant to such arrangement, Business Associate or Qualified Service Organization may be considered a "Business Associate or Qualified Service Organization" of Covered Entity as defined in the HIPAA Security & Privacy Rule and 42 CFR, Part 2 (the agreement evidencing such arrangement is entitled Purchase of Service Agreement dated _____, and is hereby referred to as the "Arrangement Agreement"); and

WHEREAS, Business Associate or Qualified Service Organization may have access to Protected Health Information (as defined below) in fulfilling its responsibilities under such arrangement;

I. DEFINITIONS

Except as otherwise defined herein, any and all capitalized terms in this Section shall have the definitions set forth in the HIPAA Privacy Rule and 42 CFR, Part 2. In the event of an inconsistency between the provisions of this Agreement and mandatory provisions of the HIPAA Privacy Rule and 42 CFR, Part 2, as amended, the HIPAA Security & Privacy Rule and 42 CFR, Part 2 shall control. Where provisions of this Agreement are different than those mandated in the HIPAA Security & Privacy Rule and 42 CFR, Part 2, but are nonetheless permitted by the HIPAA Security & Privacy Rule and 42 CFR, Part 2, the provisions of this Agreement shall control.

The term "Protected Health Information" means individually identifiable health information including, without limitation, all information, data, documentation, and materials, including without limitation, demographic, medical and financial information, that relates to the past, present, or future physical or mh/dd/sa condition or that relates to the past, present or future physical or mental health or condition of an individual with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Business Associate or Qualified Service Organization acknowledges and agrees that all Protected Health Information that is created or received by Covered Entity and disclosed or made available in any form, including paper record, oral communication, audio recording, and electronic display by Covered Entity or its operating units to Business Associate or Qualified Service Organization or is created or received by Business Associate or Qualified Service Organization on Covered Entity's behalf shall be subject to this Agreement.

II. CONFIDENTIALITY REQUIREMENTS

(a) Business Associate or Qualified Service Organization agrees:
(i) To use or disclose any Protected Health Information solely: (1) for meeting its obligations as set forth in any agreements between the Parties evidencing their business relationship or (2) as required by applicable law, rule or regulation, or by accrediting or credentialing organization to whom Covered Entity is required to disclose such information or as otherwise permitted under this Agreement, the Arrangement Agreement (if consistent with this Agreement and the HIPAA Security & Privacy Rule and 42 CFR, Part 2), or the HIPAA Security & Privacy Rule and 42 CFR, Part 2, and (3) as would be permitted by the HIPAA Security & Privacy Rule and 42 CFR, Part 2 if such use or disclosure were made by Covered Entity;
(ii) At termination of this Agreement, the Arrangement Agreement (or any similar documentation of the business relationship of the Parties), or upon request of Covered Entity, whichever occurs first, if feasible, Business Associate or Qualified Service Organization will return or destroy all Protected Health Information received from or created or received by Business Associate or Qualified Service Organization on behalf of covered entity that Business Associate or Qualified Service Organization still maintains in any form and retain no copies of such information, or if such return or destruction is not feasible, Business Associate or Qualified Service Organization will extend the protections of this Agreement to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information not feasible; and
(iii) To ensure that its agents, including a subcontractor, to whom it provides Protected Health Information received from or created by Business Associate or Qualified Service Organization on behalf of Covered Entity, agrees to the same restrictions and conditions that apply to Business Associate or Qualified Service Organization with respect to such information and agrees to implement reasonable

and appropriate safeguards to protect any of such information which is electronic protected health information. In addition, Business Associate or Qualified Service Organization agrees to take reasonable steps to ensure that its employees' actions or omissions do not cause Business Associate or Qualified Service Organization to breach the terms of this Agreement.

(b) Notwithstanding the prohibitions set forth in this Agreement, Business Associate or Qualified Service Organization may use and disclose Protected Health Information as follows:
(i) If necessary, for the proper management and administration of Business Associate or Qualified Service Organization or to carry out the legal responsibilities of Business Associate or Qualified Service Organization, provided that as to any such disclosure, the following requirements are met:
    (A) The disclosure is required by law; or
    (B) Business Associate or Qualified Service Organization obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies Business Associate or Qualified Service Organization of any instances of which it is aware in which the confidentiality of the information has been breached;
(ii) for data aggregation services, if to be provided by Business Associate or Qualified Service Organization for the health care operations of Covered Entity pursuant to any agreements between the Parties evidencing their business relationship. For purposes of this Agreement, data aggregation services means the combining of Protected Health Information by Business Associate or Qualified Service Organization with the protected health information received by Business Associate or Qualified Service Organization in its capacity as a Business Associate or Qualified Service Organization of another covered entity, to permit data analyses that relate to the health care operations of the respective covered entities.

(c) Business Associate or Qualified Service Organization will implement appropriate safeguards to prevent use or disclosure of Protected Health Information other than as permitted in this Business Associate or Qualified Service Organization will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of any electronic protected health information that it creates, receives, maintains, or transmits on behalf of covered entity as required by the HIPAA Security and Privacy Rule and 42 CFR, Part 2.
(d) The Secretary of Health and Human Services shall have the right to audit Business Associate or Qualified Service Organization's records and practices related to use and disclosure of Protected Health Information to ensure Covered Entity's compliance with the terms of the HIPAA Security & Privacy Rule and 42 CFR, Part 2.

(e) Business Associate or Qualified Service Organization shall report to Covered Entity any use or disclosure of Protected Health Information which is not in compliance with the terms of this Agreement of which it becomes aware. Business Associate or Qualified Service Organization shall report to Covered Entity any security incident of which it becomes aware. For purpose of this Agreement Security incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system. In addition, Business Associate or Qualified Service Organization agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate or Qualified Service Organization of a use or disclosure of Protected Health Information by Business Associate or Qualified Service Organization in violation of the requirements of this Agreement.

III. AVAILABILITY OF PHI

Business Associate or Qualified Service Organization agrees to make available Protected Health Information to the extent and in the manner required by Section 164.524 of the HIPAA Security & Privacy Rule and 42 CFR, Part 2. Business Associate or Qualified Service Organization agrees to make Protected Health Information available for amendment and incorporate any amendments to Protected Health Information in accordance with the requirements of Section 164.526 of the HIPAA Security & Privacy Rule and 42 CFR, Part 2. In addition, Business Associate or Qualified Service Organization agrees to make Protected Health Information available for purposes of accounting of disclosures, as required by Section 164.528 of the HIPAA Security & Privacy Rule and 42 CFR, Part 2.

IV. TERMINATION

Notwithstanding anything in this Agreement to the contrary, Covered Entity shall have the right to terminate this Agreement and the Arrangement Agreement immediately if Covered Entity determines that Business Associate or Qualified Service Organization has violated any material term of this Agreement. If Covered Entity reasonably believes that Business Associate or Qualified Service Organization will violate a material term of this Agreement and, where practicable, Covered Entity gives written notice to Business Associate or Qualified Service Organization of such belief within a reasonable time after forming such belief, and Business Associate or Qualified Service Organization fails to provide adequate written assurances to Covered Entity that it will not breach the cited term of this Agreement within a reasonable period of time given the specific circumstances, but in any event, before the threatened breach is to occur, then Covered Entity shall have the right to terminate this Agreement and the Arrangement Agreement immediately.

V. MISCELLANEOUS

Except as expressed herein by DHHS or the HIPAA Security & Privacy Rule and 42 CFR, Part 2, the Parties to this Agreement do not intend to create any rights in any third Parties. The obligations of Business Associate or Qualified Service Organization under this Section shall survive the expiration, termination, or cancellation of this Agreement, the Arrangement Agreement and/or the business relationship of the Parties, and shall continue to bind Business Associate or Qualified Service Organization, its agents, employees, contractors, successors, and assigns as set forth herein.

This Agreement may be amended or modified only in writing signed by the Parties. No Party may assign its respective rights and obligations under this Agreement without the prior written consent of the other Party. None of the provisions of this Agreement are intended to create, nor will they be deemed to create any relationship between the Parties other than that of independent Parties contracting with each other solely for the purposes of effecting the provisions of this Agreement and any other agreements between the Parties evidencing their business relationship. This Agreement will be governed by the laws of the DHHS of North Carolina. No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

The Parties agree that, in the event that any documentation of the arrangement pursuant to which Business Associate or Qualified Service Organization provides services to Covered Entity contains provisions relating to the use or disclosure of Protected Health Information which are more restrictive than the provisions of this Agreement, the provisions of the more restrictive documentation will control. The provisions of this Agreement are intended to establish the minimum requirements regarding Business Associate or Qualified Service Organization's use and disclosure of Protected Health Information.

In the event that any provision of this Agreement is held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions of this Agreement will remain in full force and effect. In addition, in the event a Party believes in good faith that any provision of this Agreement fails to comply with the then-current requirements of the HIPAA Security & Privacy Rule and 42 CFR, Part 2, such Party shall notify the other Party in writing. For a period of up to thirty days, the Parties shall address in good faith such concern and amend the terms of this Agreement, if necessary to bring it into compliance. If, after such thirty-day period, the Agreement fails to comply with the HIPAA Security & Privacy Rule and 42 CFR, Part 2, then either Party has the right to terminate upon written notice to the other Party.

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the day and year written above.

COVERED ENTITY:	*BUSINESS ASSOCIATE OR QUALIFED SERVICE ORGANIZATION:*
By: _____	*By:* _____
Title: _____	*Title:* _____